California's Duals Demonstration

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Medicare & Medi-Cal Demonstrations

- **Demonstration Goals:**
  - Coordinate Medi-Cal and Medicare benefits: medical, mental health, home & community based, and institutional long-term care services.
  - Maintain beneficiary's health and help them to remain in their homes and communities.
  - Create a single financing stream, channeled through a full-risk-bearing entity that aligns incentives to promote care coordination at beneficiary level.

California Duals

- Duals as beneficiaries who have Medicare Part A, B, and D benefits and are also eligible for full scope Medi-Cal.
- Approximately 1.1 million dually eligible in CA.
- Roughly 10% of Medi-Cal population and $8.6 billion in Medi-Cal costs **= Nearly 25% of Medi-Cal costs.**
- In 2007, duals comprised 21 percent of the Medicare population, but 36 percent of Medicare spending.

Spending on Duals

Table 1: Medicare and Medi-Cal Expenditures for Dual Eligibles, 2007

	Expenditures	Enrollment	Per Capita Cost
Disabled	$5.45 billion	395,808	$13,770
Aged	$11.4 billion	511,030	$22,306
Blind	$247 million	12,754	$19,333
LTC	$3.75 billion	67,803	$55,321
Other	$148 million	25,364	$5,831
Total	**$21 billion**	**985,383**	**$21,396**

Source: DHCS RASS using Medicare and Medi-Cal aid claims data from Jan. 1 2007-Dec. 31, 2007

Challenges with Status Quo

- Currently 75% of California's dual eligibles navigate two separate health care systems on their own. This leads to many problems, including:
  - Different coverage rules
  - Poor care coordination
  - Lack of shared data
  - Misaligned financial incentives
  - **Result= fragmented, inefficient care, high utilization of institutional services**

Medicare and Medi-Cal: Division of Responsibility

Medicare	Medi-Cal
• Acute (hospital) services • Outpatient services (physicians and other qualified providers) • Temporary skilled nursing facility services • Rehabilitation services • Home health services • Dialysis • Durable medical equipment • Prescription drugs • Hospice	• Services not covered by Medicare, including transportation, vision, some mental health services • Cost-sharing for Medicare (Part A & B deductibles, Part B premiums and coinsurance) • Skilled nursing facilities after Part A benefits are exhausted • Home health, personal care services, and other home-based services not covered by Medicare • Portion of the cost for prescription drugs • Durable medical equipment not covered by Medicare

Source: Medicare Payment Advisory Commission, 2011

Affordable Care Act on Duals

- Created the Medicare-Medicaid Coordination Office.
- Purpose: Improve quality, reduce costs, and improve the beneficiary experience.
- CA is one of the 15 states selected to receive up to $1 million to design new models for serving Medicare-Medicaid enrollees.

Demonstration Timeline

- Spring 2011: DHCS released an RFI
- August 30th 2011: RFI Conference in Sacramento
- Fall 2011: Stakeholder Outreach & Policy Development
- December 2011: DHCS will release its RFS for those organizations who want to be sites
- Spring 2012: Sites will be selected with a CMS required public comment period.
- January 1, 2013: Demonstrations will begin

Stakeholder Outreach

- Shares the goal of consumers and advocates in creating an interactive exchange of ideas regarding program design.
- Actively seeks input from a range of stakeholders, including consumers, advocates, providers, health plans, and researchers.
- Numerous individual meetings, as well as group meetings, have been held and will continue to do so.
- Will host three public forums in early December for comments.

Policy Development

- Open, interactive exchange of ideas.

- Stakeholder input from a diversity of folks will be sought around key issue areas, including:
  - **Long-term care services,**
  - **Behavioral health, and**
  - **Consumer protections**.

- Key frameworks and policy options have been developed and discussed with stakeholders.

Site Selection Process

- **SB 208 (2010):**
  - Demonstrations in up-to four counties.
  - One two-plan model county.
  - One county organized health county.

- **Under SB 208, the director shall consider:**
  - Local support for integrating medical care, long-term care, and home and HCBS; and
  - Input from health plans, providers, community programs, consumers, and other stakeholders.

Request for Solutions (RFS)

- Criteria for a number of issue areas and for applicants to demonstrate their ability to satisfy all criteria.

- Assess all entities through a pass-fail lens; all entities meeting or exceeding the high bar permitted to enter the operations planning phase.

- Once sites are selected through this process, each will have to engage in rate negotiation and detailed readiness assessments.

Finance Models

- Integration of all current fee-for-services spending by Medicare and Medi-Cal on the Duals: all medical services, mental health services, home & community based services and nursing home services.
- In a September, DHCS sent a letter of intent to CMS identifying two financial models the state would be pursuing:
  - **Capitated model**: CMS, the State, and health plans would enter into a three-way contract.
  - **Managed FFS model**: CMS and a State will enter into savings agreement.
- DHCS is having conversations with CMS regarding the development of the finance mechanism.

Evaluation Framework

- Demonstrations will be evaluated on clinical improvements and efficiencies, as well as on their care coordination activities.

- DHCS will collect qualitative and quantitative data through:
  - Survey of enrollees;
  - Medicare and Medi-Cal claims and encounter data; and
  - Enrollment data.

Evaluation Framework

- **Evaluation Framework will include:**
  - Enrollment and Retention of Beneficiaries in Demonstrations
  - Care Coordination, Access and Continuity
  - Integrating Behavioral Services
  - Beneficiary Health Outcomes/Health Status
  - Utilization of Hospitals and Nursing Homes
  - Beneficiary Satisfaction
  - Provider Satisfaction
  - Cost Saving and Slower Budgetary Growth

Questions?